



INdiana Scheduled Prescription Electronic Collection & Tracking Program

Error Submission Form

Pharmacy Information:

Name: _____

Pharmacy NCPDP#: _____

Telephone: _____

Contact Person: _____

Total number of prescriptions included: _____

Number of error(s) corrected: _____

Date Range: From: _____ to: _____

**THIS FORM MUST BE COMPLETED AND
ENCLOSED WITH YOUR RESUBMISSION**

Mail To:

Controlled Substances Advisory Committee
ATTN: INSPECT Program
402 West Washington Street, Room W072
Indianapolis, IN 46204

FAX: 317.233.4236

Email: inspect@pla.in.gov

(Please keep a copy of this form for your records and make copies for future use)